STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005052	A. BUILDING: _____ B. WING _____	12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST FRANCIS HEALTH - MOORESVILLE	1201 HADLEY RD MOORESVILLE, IN 46158

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This was a State hospital complaint investigation. Complaint: #IN00150021 Unsubstantiated: Lack of sufficient evidence. Facility Number: 005052 Survey Date(s): 12/17/2014 Surveyors: Saundra Nolfi, RN Public Health Nurse Surveyor Franciscan St. Francis Health Mooresville is in compliance with 410 IAC 15-1.5-10, Discharge Planning Services, Hospital Licensure Rules. QA Review: JLee 01-22-15	S 000		